DEPARTMENT OF THE NAVY
BOARD FOR CORRECTION OF NAVAL RECORDS
2 NAVY ANNEX
WASHINGTON DC 20370-5100

JRE
Docket No: 7858-97
5 June 2000

[redacted]

Dear [redacted]

This is in reference to your application for correction of your naval record pursuant to the provisions of title 10 of the United States Code, section 1552.

A three-member panel of the Board for Correction of Naval Records, sitting in executive session, considered your application on 1 June 2000. Your allegations of error and injustice were reviewed in accordance with administrative regulations and procedures applicable to the proceedings of this Board. Documentary material considered by the Board consisted of your application, together with all material submitted in support thereof, your naval record and applicable statutes, regulations and policies. In addition, the Board considered the advisory opinions furnished by the Specialty Leader for Pulmonary and Critical Care Medicine dated 11 August 1999 and 4 April 2000, and the Director, Naval Council of Personnel Boards dated 17 November 1999, your rebuttal thereto, and the comments of your counsel. A copy of each opinion is attached.

After careful and conscientious consideration of the entire record, the Board found that the evidence submitted was insufficient to establish the existence of probable material error or injustice. In this connection, the Board substantially concurred with the comments contained in the advisory opinion provided by the Director, Naval Council of Personnel Boards.

The Board noted that your pulmonary condition was of long standing, and did not cause significant functional impairment prior to your discharge from the Navy, which appears to have been completely voluntary. The fact that you were exempted from portions of the physical readiness test on several occasions did not mandate your referral to a medical board as your counsel maintains; rather, OPNAVINST 6110.1D, then in effect, provided that referral to a medical board in cases such as yours would occur "if appropriate", and then only upon the recommendation of a medical specialist. The Board noted that you concealed your history of pulmonary complaints when examined in connection with your application for a commissioning program on 6 February 1996, and stated you were in good health and not taking any medication when you underwent your pre-separation physical examination on 23

December 1996. The Board concluded that you exaggerated your pulmonary symptoms when you were examined by Department of Veterans Affairs (VA) physicians in connection with your claim for disability benefits shortly after you were discharged . The Board did not accept your contention to the effect that you had no alternative but to accept discharge because you had not been advised of your options or told that you would be considered for "a medical discharge". In this regard, the Board noted that you were qualified as an independent duty corpsman, and it concluded that you would have been aware of the rights and procedures associated with disability evaluation processing.

In view of the foregoing, your application has been denied. The names and votes of the members of the panel will be furnished upon request.

It is regretted that the circumstances of your case are such that favorable action cannot be taken. You are entitled to have the Board reconsider its decision upon submission of new and material evidence or other matter not previously considered by the Board. In this regard, it is important to keep in mind that a presumption of regularity attaches to all official records. Consequently, when applying for a correction of an official naval record, the burden is on the applicant to demonstrate the existence of probable material error or injustice.

Sincerely,

W. DEAN PFEIFFER
Executive Director

Enclosure

Pulmonary Division
National Naval Medical Center
8901 Wisconsin Avenue
Bethesda MD 20889-5600
(301) 295-4217
Fax: (301) 295-2831

4 April 2000

From: Specialty Leader, Pulmonary & Critical Care Medicine
To : Chairman, Board for Correction of Naval Records

Subj: APPLICATION FOR CORRECTION OF NAVAL RECORDS IN THE CASE OF FORMER [redacted]

Encl: (1) BCNR File
(2) Service Records
(3) Medical Records

Ref: (a) Letter from Chairman, BCNR, Docket No: 7858-97, dated 02 Feb 00

1. Per your request, Encl (1) – (3) were reviewed again, with specific attention to the questions in paragraph three of Ref (1). Each of the questions is considered separately below. Additional comments regarding my phone conversation with [redacted], referenced in the initial response to former HM1 (SW) Peters' application are also included.

2. The pulmonary function tests provided in the records, dated 31 October 1996 and 14 November 1996 both demonstrate consistent results and meet acceptability criteria published by the American Thoracic Society. The use of $FEV_{0.5}$ as a marker of patient effort is not currently recommended (the back extrapolated volume is the correct criteria and this number is low, consistent with a good initial effort). The patient's $FEV_{0.5}$ is similar to the FEV_1 as a percentage of the predicted value and does not, in my opinion, appear represent poor initial effort. It should also be noted that submaximal initial efforts could result in either lower or higher FEV_1s, since less forceful efforts are less likely to cause dynamic collapse of the airway.

3. Prednisone at high doses certainly can improve exercise performance by relieving bronchospasm. In this case however, the prednisone was prescribed on 31 October 1996 and at follow-up on 14 November 1996, the doctor indicated that the medication had been taken for 10 days and had been stopped. There was no significant change in spirometry and the patient indicated no symptomatic improvement. The cardiology evaluation did not occur for another 29 days and it is unlikely that a steroid effect would have been present more than a month after treatment was stopped. (It is possible that prednisone was restarted, but there is no documentation of this in the record and the cardiology evaluation does not identify active steroid use.)

4. The Bruce protocol results, as reported, do not correlate with severe dyspnea at 50 yards. There is variability in airway caliber with asthma and COPD, and patients can have good and bad days, but the baseline FEV_1 and the performance on exercise testing would argue against the extreme dyspnea described.

5. The Bruce protocol results, unfortunately, cannot be used as a surrogate for formal cardiopulmonary exercise testing. Eleven METs should correlate to a normal maximal oxygen consumption in a person without active cardiopulmonary disease. There is no data for correlating METs in patients with cardiopulmonary disease and the principal textbook on exercise testing lists several reasons why there may be problems with this approximation of maximal oxygen consumption. As noted above, this test indicates that severe dyspnea at 50 yards, consistently limiting activity, is not likely. It does not; however, address pulmonary limitations to sustained exercise/work and cannot be substituted for a cardiopulmonary exercise test. There is also no data correlating performance on a Bruce protocol to exercise capacity in the workplace, unlike formal cardiopulmonary exercise testing. It also does not address the effect of variability of lung function, which is a significant problem in patients with asthma and in some patients with COPD.

6. My comments to [redacted], noted in the initial response to [redacted] request appear to be misstated. I indicated that there were patients who perform better than PFTs would predict. This is well documented in the medical literature, as are patients in who resting PFTs overestimate performance. I have no direct knowledge of Mr. Peters' exercise performance and do not think that his performance on the cardiac treadmill test can be used mitigate complaints of chest tightness and exercise limitation consistently present over several years or to determine that a ventilatory limitation to exercise does not exist.

7. In summary, [redacted] performance on pulmonary function testing appears to be a maximal effort by commonly accepted criteria, is reproducible on individual test days, and is consistent on testing several weeks apart. I have no doubt that [redacted] had a ventilatory impairment and that this impairment limited his exercise capacity, although severe dyspnea at 50 yards would seem unlikely. Prednisone does not appear to be a factor in the results of the treadmill test, but the results of that single test cannot be used to assess exercise performance or the severity of a cardiac or ventilatory impairment. My initial recommendations in this case, outlined in my original review, remain unchanged.

8. Please feel free to contact me at the telephone number listed above if clarification of my response or additional input is needed.

[redacted]
CAPT(sel), MC, USN